Instructions for Reporting Health Care Reimbursement Rate Information

Introduction

This document sets forth the instructions for submitting data according to the rules in Title 28 Texas Administrative Code, Chapter 21, Subchapter KK.

Definitions

Allowed Amount: The amount that the applicable health benefit plan issuer allows as reimbursement for a health care service or group of services, including reimbursement amounts for which a patient is responsible due to deductibles, copayments, or coinsurance.

Ambulatory Surgical Center: A facility licensed under Health and Safety Code Chapter 243

Applicable Health Benefit Plan: As specified in Insurance Code Section 38.352, a preferred provider benefit plan as defined by Insurance Code Section 1301.001, including an exclusive provider benefit plan consistent with Insurance Code Section 1301.0042, or an evidence of coverage for a health care plan that provides basic health care services as defined by Insurance Code Section 843.002. The term does not include a health maintenance organization plan providing routine dental or vision services as a single health care service plan or a preferred provider benefit plan providing routine vision services as a single health care service plan.

Billed Amount: The amount charged for medical care or health care services on a claim submitted by a provider.

Facility Claims: Any claim for health care services provided by a facility as defined in Section 3.3702 of this title.

Geographic Regions: A three-digit ZIP code, representing the collection of ZIP codes that share the same first three digits. For purposes of data submitted pursuant to this subchapter, a geographic region must be located in Texas, in full or in part.

Imaging Claims: Claims for radiological services furnished in a provider office, outpatient hospital, or other outpatient environment.

Inpatient Procedure Claims: Claims for health care services furnished in a hospital as defined by Insurance Code Section 1301.001 to a patient who is formally admitted.

In-Network Claims: Claims filed with an applicable health benefit plan for medical or health care treatment, services, or supplies furnished by a provider that is contracted as an in-network or preferred provider.

Medical Billing Codes: Standard code sets used to bill for specific medical services, including the Healthcare Common Procedure Coding System (HCPCS) and diagnosis-related group (DRG) system established by the Centers for Medicare and Medicaid Services (CMS), the current procedural terminology (CPT) code set maintained by the American Medical

Association, and the international classification of diseases (ICD) code sets developed by the World Health Organization.

Out-of-Network Claims: Claims filed with an applicable health benefit plan for medical or health care treatment, services, or supplies furnished by a provider that is not contracted as an in-network provider or preferred provider.

Outpatient Facility Procedure Claims: Claims for health care services furnished in an ambulatory surgical center or a hospital as defined by Insurance Code Section 1301.001 to a patient who is not formally admitted.

Place of Service Code: For purposes of data submitted under Title 28 Texas Administrative Code, Chapter 21, Subchapter KK, place of service refers to the type of entity where services were rendered, as specified by a two-digit place of service code on a professional health care claim, consistent with the Accredited Standards Committee X12N (ASC X12N) standard for electronic transactions. Place of service codes are maintained by the CMS. Please see the following subset of descriptions.

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility established for the primary purpose of education.
04	Homeless Shelter	A facility or location established for the primary purpose of providing temporary housing to homeless individuals (for example, emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, that provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, that provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal Organization under a 638 agreement that provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement that provides diagnostic,

Place of Service Code(s)	Place of Service Name	Place of Service Description
		therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/ Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Unassigned	
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours-a-day, 7 days-a-week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social or behavioral services, custodial service, and minimal services (for example, medication administration).
15	Mobile Unit	A facility or unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, camp ground, hostel, cruise ship, or resort where the patient receives care, and which is not identified by any other place of service code.
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy, or independent clinic, and not described by any other place of service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18	Place of Employment-Worksite	A location, not described by any other place of service code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides ongoing or episodic occupational medical, therapeutic, or rehabilitative services to the individual.
19	Unassigned	N/A
20	Urgent Care Facility	A location, distinct from a hospital emergency room, an office, or a clinic, in which health care providers diagnose and treat

Place of Service Code(s)	Place of Service Name	Place of Service Description
		illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, in which patients are provided with diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to persons who are sick or injured but who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A part of a hospital in which emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery, and immediate post-partum care, as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the uniformed services. Military treatment facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as uniformed service treatment facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services, but it does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility that primarily provides skilled nursing care and related services to residents for the rehabilitation of injured, disabled, or sickness, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
33	Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, and that does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A

Place of Service Code(s)	Place of Service Name	Place of Service Description
41	Ambulance - Land	A land vehicle specifically designed, equipped, and staffed for life saving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped, and staffed for life saving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other place of service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center (CMHC)	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour-a-day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to state mental health facilities to determine the appropriateness of an admission; and consultation and education services.
54	Intermediate Care Facility/Intellectually Disabled	A facility that primarily provides health-related care and services above the level of custodial care to individuals with intellectual disabilities but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility that provides treatment for substance (alcohol and drug) abuse to residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, medications and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility, or distinct part of a facility, for psychiatric care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

Place of Service Code(s)	Place of Service Name	Place of Service Description
57	Nonresidential Substance Abuse Treatment Facility	A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility, other than a hospital, that provides dialysis treatment, maintenance, or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility that is located in a rural, medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above

Primary Plan: Consistent with 28 Texas Administrative Code, Section 3.3503(18), a plan whose benefits for a person's health coverage must be determined without taking the existence of any other plan into consideration.

Professional Claims: Any claim for health care services provided by a physician or health care provider that is not an institutional provider, as defined in Insurance Code Section 1301.001.

Provider: Any physician, practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state.

Reporting Period: The 12-month interval for which a plan or health benefit plan issuer must submit data each year, beginning each January 1 and ending December 31 of the same year.

Total Claim Units: The total number of final adjudicated separate claims for which an applicable health benefit plan issuer furnishes reimbursement for a specified medical billing code or group of codes. This term includes covered claims for which some or all of the reimbursement is attributed to patient responsibility such as deductibles, copayments, or coinsurance, and excludes claims for which the applicable health benefit plan is a secondary plan.

Unique Claim ID: An identifier that is specific to an individual claim for services provided to an insured. The number of unique claim IDs is used to indicate the number of separate encounters for professionals and outpatient institutions included in the total billed and allowed amount fields for a given code received in a given 3-digit ZIP code.

Units of Service: The total number of units billed for a given medical billing code in a given 3-digit ZIP code. This term is a measure of medical services provided, such as the number of hospital days, minutes of anesthesia, or 15-minute increments of therapy.

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1. Reporting Period: TDI will pre-populate this field with the year that corresponds to the current reporting period.
2. Company or Plan Name: Enter the company name, or enter the plan name if there is not a company name.
3. NAIC Company No.: Enter the health benefit plan issuer's NAIC company number or "n/a" if not applicable.
4. TDI Company No.: Enter the health benefit plan issuer's TDI company number or "n/a" if not applicable.
5. Contact Information: Enter the contact name (first and last name) and title of the person designated by the company or plan to discuss the report with TDI staff. Enter the contact person's direct telephone number and extension, if applicable, and email address. Check "yes" to indicate that TDI may release the contact person's email address or "no" to request that TDI not release the email address.
6. Business Type: Check the appropriate box to indicate whether the report is for health insurance business (PPO, EPO) or HMO business (HMO, POS). Reimbursement rate information must be reported separately for insurance and HMO business, regardless of whether a group health benefit plan issuer provides both insurance and HMO coverage under a single company number. Indicate "n/a" if reporting is limited to self-insured business.
7. Reporting on Behalf of Governmental or Other Self-Insured Plans: If your data submission includes data on self-insured business, check the box or boxes to indicate the type of self-

insured data included. Insurance Code Chapter 38, Subchapter H requires certain governmental plans to report:

- a basic coverage plan under Insurance Code Chapter 1551,
- a basic plan under Insurance Code Chapter 1575,
- a primary care coverage plan under Insurance Code Chapter 1579, and
- a basic coverage plan under Insurance Code Chapter 1601.

Data for governmental plans may be submitted separately or may be combined with other data being submitted by the entity authorized to report.

8. Electronic Signature and Certification of Data: Enter the name as an electronic signature of the individual authorized by the plan or health benefit plan issuer certifying that the information provided is a full and true statement of the data required in accordance with the instructions provided according to the best of the individual's information, knowledge, and belief.

Scope of Data Required

The data requested is intended to allow TDI to publicly display an accurate range of probable expenses related to certain medical services and procedures. Data submitted will be aggregated before being made available to the public, in the form of an average or median cost and a range of costs that a consumer is most likely to experience for a treatment event.

Applicable Data

In reporting data, issuers must:

- Report data elements according to medical billing codes specified in the instructional data tables and limit claims to those for services received in the place of service indicated.
- Separately report data for insurance and HMO business and exclude any HMO claims paid in through a capitation agreement.
- Separately report data for in-network and out-of-network claims.
- Limit data to include only:
  - Claims incurred and adjudicated during the 12-month reporting period. For the 2015 reporting period, limit data for inpatient procedure claims and outpatient procedure claims to claims incurred and adjudicated prior to October 1, 2015, or the date on which the issuer transitioned billing systems to use ICD-10 procedure codes.
  - Claims for which adjudication is final; exclude pending or denied claims
  - Claims for insureds in commercial fully insured plans or self-funded employer group plans; exclude any claims Medicare supplement products
  - Claims for which the issuer is the primary plan responsible for payment; exclude claims for which issuer is the secondary plan
  - Claims with an allowed amount greater than zero.

Organizational Fields

A. 3-Digit ZIP Code – All data should be reported by the service provider 3-digit ZIP code. The data reporting template lists each 3-digit ZIP code. Provide data for each 3-digit ZIP code in which applicable claims occur.

B. Target Codes or Billing Code – This field will be pre-populated by TDI with the target medical billing code(s) requested.
C. Modifier – This field will be pre-populated with modifiers, where applicable
    - 26 – include all claims for the given billing code when accompanied by modifier 26
    - TC – include all claims for the given billing code when accompanied by modifier TC
    - None – include claims for the given billing code only when accompanied by no modifier
    - All others – include all claims for the given billing code when accompanied by any modifier excluding those collected separately (26, TC).
D. Place of Service – This field will be identified in each data table to indicate the applicable places of service.

Data Reporting Templates

Issuers may comply with the data reporting requirements by submitting data in the data reporting templates provided. Corresponding instructional data tables provide specific instructions for the filter process to derive the requested data. Reporting templates are provided for the following categories:

- Inpatient procedures as derived from institutional claims
- Physician services for reported inpatient procedures as derived from professional claims
- Outpatient facility procedures as derived from institutional claims
- Physician services for reported outpatient facility procedures as derived from professional claims
- Physician ambulatory or office based procedures as derived from professional claims
- Pathology professional procedures as derived from professional claims
- Imaging services as derived from professional claims or outpatient facility claims.

Data Fields

The following fields are subject to the same instructions for both in-network and out-of-network claims. For applicable data in a given 3-digit ZIP code, report the following for each field:

1. **Number of Claims:** Report the total count of claims from which the data is derived.
2. **Number of Discharges:** Report the total count of discharges that reflect one unique inpatient stay. Count of discharges may vary from count of claims due to the possible occurrence of more than one claim submitted per discharge. This calculation may require the aggregation of claims that collectively report one inpatient stay/discharge.
3. **Total Amount Billed:** Report the aggregated dollar amount billed for the requested procedure for the total number of applicable claims or discharges.
4. **Total Allowed Amount:** Report the aggregated dollar amount allowed for the requested procedure for the total number of claims or discharges.
5. **Mean Billed Amount:** Report the computed mean dollar amount billed for the requested procedure for the total number of claims or discharges.
6. **Mean Allowed Amount:** Report the computed mean dollar amount allowed for the requested procedure for the total number of claims or discharges.

7. **Median Billed Amount:** Report the computed median dollar amount billed for the requested procedure for the total number of claims or discharges.
8. **Median Allowed Amount:** Report the computed median dollar amount allowed for the requested procedure for the total number of claims or discharges.
9. **Maximum Billed Amount:** Report the maximum dollar amount billed for the requested procedure.
10. **Maximum Allowed Amount:** Report the maximum dollar amount allowed for the requested procedure.
11. **Minimum Billed Amount:** Report the minimum dollar amount billed for the requested procedure.
12. **Minimum Allowed Amount:** Report the minimum dollar amount allowed for the requested procedure.
13. **25th Percentile Billed Amount:** Report the dollar amount billed for the requested procedure that marks the 25th percentile of billed amounts.
14. **25th Percentile Allowed Amount:** Report the dollar amount allowed for the requested procedure that marks the 25th percentile of allowed amounts.
15. **75th Percentile Billed Amount:** Report the dollar amount billed for the requested procedure that marks the 75th percentile of billed amounts.
16. **75th Percentile Allowed Amount:** Report the dollar amount allowed for the requested procedure that marks the 75th percentile of allowed amounts.